

~ METHADONE 40 MG DISPERSIBLE TABLETS ~**Prior Authorization Request Form**

Vermont Medicaid has established coverage limits and criteria for prior authorization of methadone 40mg dispersible tablets. These limits and criteria are based on concerns about safety and the potential for abuse and diversion. In order for beneficiaries to receive coverage for this drug, it will be necessary for the prescriber to complete and fax this form to MedMetrics Health Partners. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549**Prescribing physician:**

Name: _____

Phone #: _____

Fax #: _____

Address: _____

Beneficiary:

Name: _____

Medicaid ID #: _____

Date of Birth: _____ Sex: _____

Contact Person at Office: _____

Dose/Frequency and Length of Therapy: _____

Diagnosis or Indication for Use: _____

Due to reports of death and life-threatening adverse events such as respiratory depression and cardiac arrhythmias in patients receiving methadone, the FDA has issued an alert for healthcare providers. The FDA made the following recommendations (for more details, go to www.fda.gov/cder/drug/InfoSheets/HCP/methadoneHCP.pdf):

- Avoid prescribing methadone 40 mg dispersible tablets for pain; it is only FDA-approved for detoxification and maintenance treatment of narcotic addiction. (Please note: methadone 5mg and 10mg tablets do not require prior-authorization.)
- Patients should be titrated to analgesic effect slowly even in patients who are opioid-tolerant, since methadone's elimination half-life (8-59 hours) is longer than its duration of analgesic action (4-8 hours) and cross-tolerance between methadone and other opioids is incomplete.
- This dosing scheme was derived as a guide to convert chronic pain patients to methadone from morphine. See the methadone label (Dolophine) for more details.

| Total Daily Baseline Oral Morphine Dose | Estimated Daily Oral Methadone Requirement Percent of Total Daily Morphine Dose* |
|---|---|
| < 100 mg | 20% to 30% |
| 100 to 300 mg | 10% to 20% |
| 300 to 600 mg | 8% to 12% |
| 600 to 1000 mg | 5% to 10% |
| > 1000 mg | < 5% |

*Methadone dosing should not be based solely on this table. Dosing should always be individualized to account for the patient's general medical condition, concomitant medication, and anticipated breakthrough medication use.

Please select one of the following:

- ☐ I have read the FDA recommendations and want to continue with the methadone prescription as written.
Prescriber comments: _____

- ☐ I will be changing the methadone dose or drug selection to: _____
Prescriber comments: _____

Prescriber Signature: _____**Date of this request:** _____